DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____ AUG 2 1 2012	C 07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to notify a resident and/or Power of	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #5 was treated at the hospital and returned to the facility on 7/21/2012. Resident #5 no longer resides at the facility. 2. A review of current resident charts for the past 30 days was completed to identify any x-ray results not reported to the resident and/or Power of Attorney. This review revealed appropriate notification was completed as indicated. This review was completed on 8/9/2012.Facility licensed	8-12-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marla Haugh TITLE: CNHA, BSW (X6) DATE: 8/9/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 Attorney (POA) upon receipt of abnormal x-ray results for 1 (Resident #5) of 1 resident. Findings include: #5 DRM Resident #2 was admitted to the facility on 07/16/12. Cumulative diagnoses included progressive supranuclear palsy and early dementia. Review of the nursing admission assessment, dated 7/16/12, indicated the Resident #5 was alert and oriented, had no short or long term memory problems, and had modified independence with decisions of daily living, Review of the resident ' s admission documentation revealed contact numbers listed for the resident ' s POA. Review of Resident #5 medical record revealed the resident had an x-ray on 07/21/12. Per the record, the x-ray result was faxed to the facility on 07/21/12 at 11:30 AM and indicated the resident had a fractured clavicle. The record documentation revealed the x-ray result was faxed to the physician at 11:30 AM. Review of Resident #5's nursing notes, dated 07/21/12, indicated the resident left the facility with her family at 11:00 AM and would be returning at approximately 4:00 PM. Further review revealed Nurse #2 notified the family (name of POA) at 4:00 PM of the abnormal x-ray report which indicated the resident had a fractured clavicle. The notes continued that Resident #2 returned to the facility at 5:05 PM and was sent to the hospital at 5:20 PM.	F 157	nurses have been re-educated to document on the 24 hours report any x-rays ordered, when they are obtained, and results of the x-ray. Facility licensed nurses have been educated to call the MD and notify the resident and/or Power of Attorney upon receipt of any x-ray findings at the time of receipt by the Director of Clinical Services, Unit Manager, and Weekend supervisor by 8/12/2012. this education will be done for newly hired licensed nurses during the orientation process. The 24 hour report will be reviewed daily by the Director of Clinical Services, Unit Manager, and/or Weekend Supervisor to identify x-rays being ordered and appropriate notification of results to the doctor and resident and/or power of Attorney.	

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F 157	Continued From page 2 A phone interview, on 07/26/12 at 4:30 PM, was conducted with Nurse #2. Nurse #2 indicated she faxed the report to the physician when she received the report. She relayed that it was a very busy day with multiple nursing issues, was trying to provide care to all of the residents and had not had time to make a call to the family member/POA when she received the x-ray report. She indicated there was no staff member available to assist her with the many on-going issues. Nurse #2 relayed the facility did have a supervisor on the weekends, but the supervisor was not available to help as he was still in orientation. She indicated she also was aware the resident would be returning to the facility in the afternoon. An interview, on 07/25/12 at 12:30 PM, was conducted with Nurse #3, the weekend Nurse Supervisor. He relayed the nurse did inform him of the x-ray report for Resident #5 and he advised her to call the responsible party as soon as he was informed. Nurse #3 indicated he was not aware that that there was a period of time from the time the x-ray report was received and the responsible party was notified. He relayed the resident and/or responsible party should have been notified when the report was received even if the physician had not responded. Nurse #3 indicated the responsible party could have been advised to take the resident to the emergency room or to return to the facility so the resident could be sent from the facility to the emergency room for evaluation. He relayed Nurse #2 did know the resident would be returning to the facility in the afternoon. Nurse #3 again stated the notification should have been completed when the facility received the x-ray results since	F 157	3. A quality improvement tool will be completed 5 times per week for 2 weeks, 3 times per week f or 2 weeks, weekly for 2 weeks, then monthly for 10 months to identify appropriate notification of x-ray results. 4. The Director of Clinical Services will report the results of the quality improvement tool to the Performance Improvement committee monthly to identify trends and the need for further education and/or monitoring.	

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F 157	Continued From page 3 the resident was out of the facility with family at that time and the x-ray result indicated the resident had a fractured clavicle. An interview, on 07/25/12 at 11:45 AM, was conducted with the Director of Nursing (DON). The DON stated on 07/21/12 she received a phone call from Nurse #3 regarding the x-ray report indicating Resident #5 had a fractured clavicle. She relayed she advised Nurse #3 that the responsible party should be notified and given the options of going onto the emergency room or returning to the facility to be sent to the emergency room. The DON indicated even if the physician had not yet responded the facility staff could have sent the resident onto the emergency room for evaluation because of the x-ray results. She stated her expectation was the nurse would have notified the resident/responsible party of the x-ray results when the results were received even if the nurse was waiting for the physician's response.	F 157		

CARY HEALTH & REHABILITATION

To: Kathy Sphar RN,BS

From: Sharla Haugh
Administrator

Date: 8/27/2012

Re: Addendum to Plan of Correction dated 8/9/2012

Dear Ms. Sphar,

Please accept this as an addendum to the plan of correction dated 8/9/2012.
Per our conversation, item number 3 located on page 3 of the Plan of Correction dated 8/9/2012 The DCS/Supervisor will be the individual who will be conducting the monitoring and completing the monitoring tool mentioned. Please contact me if you have any questions or need any further documentation related to our POC. Thank you for your interaction, support and education related to this concern.

Sincerely,
Sharla Haugh
Administrator
Cary Health and Rehab